Washington State Health Care Authority

Vendor Affidavit of Lost, Stolen, or Destroyed Warrant

STATE OF WASHINGTON)
)
)

RETURN TO:
Washington State Health Care Authority
Financial Services/Accounting
PO Box 45500
Olympia, WA 98504-5500

FSA Use Only

I, _____ (print name), having been duly sworn, depose and say that I am the proper owner, payee, or legal representative of such owner or payee of the state of Washington's Warrant Number _____, dated _____,

in the amount of $_____, and that said warrant has been lost, destroyed or not delivered to me and to the best of my knowledge has not been paid. If the warrant is subsequently found, I will return the warrant.

_____ _____
PAYEE SIGNATURE PAYEE PHONE NUMBER

_____
MAILING ADDRESS CITY STATE ZIP CODE

NOTARY SEAL

State of _____

County of _____

I certify that I know or have satisfactory evidence that _____ (name of person) is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated _____ Signature _____

Title _____ My appointment expires _____

WITNESSES: REQUIRED <u>ONLY IF</u> PAYEE SIGNED BY MARK (X) ABOVE			
1	WITNESS' SIGNATURE	DATE	PRINT NAME (WITNESS' NAME) HERE
	STREET ADDRESS	CITY	STATE ZIP CODE
2	WITNESS' SIGNATURE	DATE	PRINT NAME (WITNESS' NAME) HERE
	STREET ADDRESS	CITY	STATE ZIP CODE

FOR HCA USE ONLY
WARRANT CANCELLATION AUTHORIZATION

AGENCY/SUB	ISSUE DATE	BIENNIUM		WARRANT NUMBER	
NAME				REGISTER NUMBER	
ADDRESS CITY STATE ZIP CODE			FUND	AMOUNT	
AUTHORIZED BY		TELEPHONE			
			TOTAL		

Original to Financial Services/Accounting. Keep copy for file.